Learned helplessness in doctors with dyslexia: time for a change in discourse?

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Dyslexia may be defined as a "learning difficulty that specifically impairs a person's ability to read ... despite having normal intelligence" (National institute of neurological disorders and stroke, 2011). It is a Specific Learning Difficulty (SpLD), which has an estimated international prevalence of 10% (Dyslexia International, n.d., Wray et al., 2012). Within the United Kingdom (UK), it is protected by the Equality Act of 2010 and, therefore, employers are required to make reasonable adjustments to enable individuals with dyslexia to reach their full potential within their jobs (Great Britain, 2010). However, what might this entail for a doctor? And what might a lack of such support result in?

Shea & Hurley defined helplessness as "the feeling that any effort aimed at constructive change... is doomed before it is even attempted" (Shea and Hurley, 1964). In turn, *Learned Helplessness* refers to a situation in which an individual does not try to improve or escape a harmful situation, "because the past has taught them to be helpless" (Hahner, 1989). This concept has been linked to multiple psychological theories and situations, including the Learned Helplessness model of depression (Seligman, 1975).

Working within the UK National Health Service is challenging. Staff shortages and increasing workloads may push staff to their limits (NHS Digital, 2017). As I write this, I am a newly qualified doctor – two months into my first job. As such, I regularly find myself juggling many jobs for multiple patients at all times throughout the day –

sometimes working hours past the end of my shift. Under the new junior doctor contract in the UK, we can work like this for eight days straight – with a supposed ceiling of seventy two hours within a seven day period (British Medical Association, 2017). That said, if I do not take annual leave days within such weeks, it feels standard to work over this time limit.

When working within a fast-paced clinical environment, it is easy to become overloaded with jobs. There is a pressure to work faster, and take on an ever-increasing number of jobs simultaneously. This can and has led to me confusing which jobs were required for which patients – or arriving home to remember jobs that have been forgotten, and having to call back in. If you are unable to keep up, it is easy to feel as though you are letting the team down – sometimes this is voiced, sometimes it is not. You are therefore pushed to work faster and harder. It is also not uncommon to be told "do not be negative" by colleagues if you admit to struggling and voice worries about the day ahead. Such attitudes may promote silence in those who are truly struggling – thankfully; I am not one such individual.

I have dyslexia. I was diagnosed with this when I was nineteen years old. My dyslexia has impacted upon my life and clinical practice is many ways. My experiences as a medical student with dyslexia are discussed within a previous, autoethnographic paper (Shaw et al., 2016). My main difficulties with dyslexia can be summarised thusly:

- Slow speed of reading;
- Slow speed of writing;
- Poor short-term memory (STM);
- Difficulty handling multiple tasks at once – likely due to my poor STM.

The aforementioned clinical environment pushes me to my limits. It promotes a fast and exponential learning curve – keep up or be asked why. Whilst the senior doctors are incredibly supportive, without reservation, they have their own targets to meet – more patients need seeing, and more paperwork needs completing. There is only so much your superiors can do. This environment truly tests my ability to overcome my dyslexic difficulties. My compensatory coping strategies have allowed me to complete my medical degree, and to progress into work. However, how much longer can they hold out against this fast pace and high workload without psychological consequences?

As a fairly extroverted individual, it is not uncommon for me to discuss my dyslexia with colleagues or senior doctors. When I do so, I am often not filled with hope – but with shock.

> *"What is dyslexia?"*
>
> *"What does that mean regarding your clinical practice?"*
>
> *"How can doctors with dyslexia be supported?"*
>
> *"What support do you actually need?"*

These are all questions that I have encountered from supervising doctors – both as a student and as a practicing doctor. Whilst they promote positive discussion, they also highlight a complete lack of awareness and understanding of dyslexia. To each new doctor I choose to disclose, the more I have to explain the condition and its implications.

Perhaps the most disheartening questions are the last two. The working environment is challenging to the point where I do not stop for thought. Therefore, when asked how I might be supported, I simply do not know. I am aware that I am struggling, but I do not know how this can be amended within the current culture of medicine. In a previous study of junior doctors with dyslexia, I encountered similar issues. Participants recalled

struggling, but not knowing how they could be helped – a sense of stoic acceptance (Shaw and Anderson, 2017a). They referred to work as "the real world", in which support was simply no longer offered, nor possible (Shaw and Anderson, 2017a). I empathise with this. It is hard to know that you are struggling, but to be unable to think of a way out. This in itself risks the development of Learned Helplessness – something that I have seen evidenced in other doctors.

As discussed before, when individuals develop Learned Helplessness, they may become depressed (Hahner, 1989). They may also, by definition, stop trying to escape their damaging situations – they are not helpable (Overmier and Seligman, 1967). Within the world of medicine this is a dangerous possibility – both for the individuals and for their patients. There is therefore a need to consider how this might be prevented and/or reversed.

An important concept to understand here is that of a discourse. A discourse may be defined as "a set of practices and associated structures of knowledge that are considered at any one time in history to be legitimate, or claim 'truth'. Once this discourse becomes dominant, other views are marginalized (an effect of power), and the dominant view is treated as if it were self-evident or transparent" (Bleakley et al., 2011). Therefore, considering my aforementioned discussion, one might consider a need to change the current discourse concerning dyslexia within medicine. There is a need to foster a supportive environment, in which asking for help is not seen as weakness, and admittance of difficulty is not viewed as negativity. In order to do so, there is a need to educate, to emphasize the impacts of dyslexia, and to promote a compassionate acceptance of dyslexia within the profession.

There is a need for more research concerning dyslexia in doctors, especially within the current healthcare culture in the UK. There is a need for research into the knowledge, attitudes and practices of supervising, senior doctors concerning dyslexia. There is also the need for education. Those in senior positions should have an awareness and understanding of dyslexia, alongside other SpLDs in order to effectively support their subordinates. Finally, there is a need for standardised guidelines to be developed – concerning the support and reasonable adjustment expectations for doctors with dyslexia. Alongside several colleagues, I have begun to tackle this void of research and knowledge, including a paper concerning teaching adaptations for medical students with dyslexia (Shaw and Anderson, 2017b). However, there is still a long way to go before we can fully understand and therefore adequately support doctors with dyslexia.

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